State Council on Developmental Disabilities

Form 1 (1of 2) COVER SHEET

Community Program Development Grant
Cycle 29 - FY 2006-07

Contracting Entity: _____

Address: _____

Implementing Entity: _____

Title of Proposal: _____

Amount Requested: $_____ Months of Project:_____
(Amount must match the total listed in Budget Form 6)

Phone Number: _____ Fax Number: _____

Project Director: _____ Email: _____

Authorized Official: _____ Title: _____

Address of Implementing Entity (if different from contracting entity): _____

Federal Identification or Social Security Number: _____

Is This Entity a Disabled Veteran's Business Enterprise? _____Yes _____No

Check Type of Organization: _____ Non-Profit _____ Proprietary _____Higher Education
_____ Local Government Agency _____Other (specify)

Identify the Regional Center(s) That Proposal Will Serve: _____

Identify the Area Board(s) catchment area the proposal will serve: _____

Identify the Counties were the services will be provided: _____

All proposals must focus on the Council's overarching goals of self-determination and community inclusion. These concepts may be applied within any of the State Plan Areas of Emphasis. Please indicate the PRIMARY area in which the Proposal will apply these overarching goals (if the proposal crosses all areas, please choose Community Supports):

Area of Emphasis selected must be consistence with the Concept Paper.

_____Employment _____Homes _____Education & Early Intervention
_____Child Care _____Health _____Transportation
_____Recreation _____Community Supports
_____Quality Assurance (Partners in Policymaking Model)
_____Quality Assurance (Statewide Self-Advocacy)
_____Quality Assurance (Youth Leadership Development)

Form 1 (2 of 2) (Page 2)
Checklist/Table of Contents
Community Program Development Grant
Cycle 29 - FY 2006-07

The following forms must be completed in type form, all pages must be numbered and in sequential order. Titles and subtitles as shown in the guidelines must be used.

LIST PAGE NUMBERS BELOW EACH FORM LISTED BELOW:

(Check that each document is attached and list page number.)
_____ Form 1 Cover Sheet and Checklist (Not to exceed 2 pages)
(Pages **1-2**)
_____Form 2 Project Profile (1 page), Summary (1 page) and Narrative (Not to exceed 7 pages)
(Pages _____)
_____Form 3 Project Management Plan (Not to exceed 2 pages)
(Pages _____)
_____Form 4 Personnel and Organization (Not to exceed 2 pages)
(Pages _____)
_____Form 5 Outcomes and Evaluation Plans (Not to exceed 4 pages)
(Pages _____)
_____Form 6 Budget (Not to exceed 3 pages)
(Pages _____)
_____Form 7 Continuation of Funding (Not to exceed 1 page)
(Page _____)

ATTACHMENTS:
(Check that each document is attached and that all pages have been numbered)
_____Continuation of Funding Letter
(Page _____)
_____Minimum of Three (3) Letters of Support
(Page _____)
_____Organizational Chart for the Proposed Project
(Page _____)
_____Duty Statements, Curricula Vitae, Current Licenses and Credentials
(Page _____)
Grant/Award list
(Page _____)

I certify that I have reviewed the proposal and all required documents are attached; all pages are numbered, and are true, complete and accurate.

Signature of Project Director: _____ Date: _____

State Council on Developmental Disabilities

Form 2 Project Profile Form
Project Profile, Summary & Narrative
Community Program Development Grant
Cycle 29 - FY 2006-07

1. Project Profile

Contracting Entity: _____

Title of Proposal: _____

Briefly describe type of program and services that will be provided:_____

Total number of individuals with developmental disabilities and their families that will be served by this proposal: _____Consumers _____Family Members

Describe briefly population that will be served in this proposal (e.g. multiple disabilities, where the consumers will come from):_____

List all previous SCDD Grants Awarded by a) Fiscal Year(s), b) Grant Amount(s), and c) Title of Project(s), and current status of program/grant:

_____

Refer to the Instruction on page 8 and 9 before completing the Project Summary and Project Narrative.

2. Project Summary (1 page) (Include title at top of Summary page)

3. Project Narrative (not to exceed (7) pages)

(Narrative must include subtitles a-k, beginning with:

a. "Brief history and description" and ending with **k. "Dissemination/Replication"**

Contracting Entity: _____ Title of Proposal: _____	**Form 3** **Project Management Plan** **Community Program Development Grant** **Cycle 29 - FY 2006-07**						
List Project Activities/Services	**Check the Month(s) Activities/Services will be Provided**						**Identify Staff Title for Each Activity/Service**
	Month 1	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	

Contracting Entity: _____ Title of Proposal: _____	**Form 3** **Project Management Plan** **Community Program Development Grant** **Cycle 29 - FY 2006-07**						
List Project Activities/Services	**Check the Month(s) Activities/Services will be Provided**						**Identify Staff Title for Each Activity/Service**
	Month 7	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	

Form 4
Personnel and Organization
Community Program Development Grant
Cycle 29 - FY 2006-07
(Not to exceed two pages.)

Contracting Entity:_____

Name of Proposal:_____

Provide a narrative for all personnel working on the project. Only the personnel listed will receive reimbursable expenses. (See page 9 for complete instructions.)

The duty statements, curricula vitae, current professional licenses and credentials are not part of the required 2 pages but are to be included as attachments at the end of the proposal package (See Form 1, page 2 for order).

1. **Personnel** _____

State Council on Developmental Disabilities

Form 5
Outcomes and Evaluation Plans (Not to exceed 4 pages)
Community Program Development Grant
Cycle 29 - FY 2006-07

Contracting Entity_____
Name of Proposal:_____

As part of the California State Council on Developmental Disabilities State Plan, the Council provides funding for new and innovative approaches to serving Californians with developmental disabilities that are part of an overall strategy for systemic change. The Council's upcoming State Plan will focus on two overarching goals:

1. Californians with developmental disabilities and their families have choice and control over their services and supports.
2. Californians with developmental disabilities and their families are fully included in all aspects of community life.

A. Briefly describe how your proposal will address an overall strategy for systemic change toward these goals._____

B. The federal government requires grantees to track and evaluate consumer satisfaction with Council funded projects (see required format in appendix). Describe how your program will track and evaluate consumer satisfaction to ensure that consumers are benefiting from this project.

_____

C. List the total number of individuals with developmental disabilities and their families that will be served by this project, and indicate under which definition of developmental disabilities (State or Federal definition, see the Glossary of Terms) they qualify.

_____

D. Indicate which Council Outcome measures (See Appendix, page 40) will be used to report outcomes for this project and describe the methodology that will be used. [Note: These federally-required measures are subject to change.]

_____

State Council on Developmental Disabilities
Contracting Entity:
Title of Proposal:

Form 6
Budget (Complete Excel Spreadsheet)
Community Program Development Grant
Cycle 29 - FY 2006-07

A. PERSONNEL SERVICES - STAFF SALARIES, WAGES, and BENEFITS

Position Title	((Monthly Salary + Monthly Benefit)) Amount	x Percent of Time Working on Project	x Months Working on Project	=Total:
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$

A. Total Personnel Costs: $_____

B. CONSULTANTS CONTRACT COST

Position Title:	(Hourly Rate)	x (Number of Hours)	= Total:
1.			$
2.			$
3.			$

B. Total Consultant Costs: $_____

C. OPERATING COSTS: (LIST ONLY THE OPERATING COSTS THAT APPLY.)

1. Postage _____
2. Printing/Copying _____
3. Office Utilities _____
4. Telephone _____
5. Office Supplies _____
6. Staff Travel _____ (Rate per Mile:_34.5 Number of Miles:_____)
7. Office Rent _____ (Rate per Sq. Ft.: ____/Number of Sq. Ft.: _____)
8. Training _____
9. Equipment _____

C. Total Operating Costs: $_____

SUBTOTAL (Sum of A+B+C) $_____

D. ADMINISTRATION/INDIRECT COSTS (10% Maximum) $_____

TOTAL CONTRACT COST (Sum of A+B+C+D): $ _____

Form 6 Sample Budget
Community Program Development Grant
Cycle 29 - FY 2006-07

A. PERSONNEL SERVICES - STAFF SALARIES, WAGES and BENEFITS

Position Title	(Monthly Salary	+ Benefit Amount)	x Percent of Time Working on Project	x Months Working on Project	= Total:
1.Executive Director	$ 6,250	$1,562	50%	18	$ 70,308.00
2 Social Worker	$ 5,000	$1,250	50%	12	$ 37,500.00
3.					$
4					$
5					$
6					$

A. Total Annual Personnel Costs: $ 131,869.00

B. CONSULTANTS SALARY/CONTRACT COSTS

Position Title:	(Hourly Rate)	x	(Number of Hours):	= Total:
1. Licensed Psychologist	$ 100.00 Per Hour		168	$ 16,800.00
2.				$
3.				$
4.				$
5.				$

B. Total Annual Consultant Costs: $ 16,800.00

C. OPERATING COSTS

1. Postage	$ 200.00	8. Training	$2,500.00
2. Printing/Copying	$ 500.00	9. Equipment	$4,900.00
3. Office Utilities	$ 1,200.00		
4. Telephone	$ 1,200.00		
5. Office Supplies	$ 2,000.00		
6. Staff Travel	$ 1,095.03 (Rate per Mile:0.345 /Number of Miles:3,174)		
7. Office Rent	$15,000.00 (Rate per Sq. Ft.: 1.25/Number of Sq. Ft.: 1,000)		

C. Total Annual Operating Costs: $ 28,595.03

SUBTOTAL (Sum of A+B+C)	**$ 177,264.03**
D. Administration/Indirect Costs (Maximum10%)	**$17,726.41**
TOTAL CONTRACT COST (Sum of A+B+C+D):	**$ 194,990.44**

State Council on Developmental Disabilities

Contracting Entity:_____

Name of Proposal:_____

Form 6
SAMPLE BUDGET JUSTIFICATION
Community Program Development Grant
Cycle 29 - FY 2006-07

A. **Personnel Services - Staff Salaries, and Benefits**

The program has budgeted one half-time Executive Director and one half-time Social Worker. Staff benefits; may include payroll taxes, workers' compensation, medical/dental insurance, vacation, holidays, and any additional benefits paid to staff.

B. **Consultants Salary/Contract Costs**

The program has budgeted one Licensed Psychologist for 168 hours at $100.00 per hour. The Licensed Psychologist will provide direct psychological services to patients. A licensed Psychologist is needed for the services provided in this proposal.

C. **Operating Costs (List Operating Costs by line items –all.)**

1. Postage includes regular mail.
2. Printing and copying for mailing and copy services to distribute reports.
3. Office Utilities to cover electricity at $100.00 per month.
4. Telephone expenditures for 3 lines at $100.00 per month.
5. Office Supplies includes cost of copy paper, desk supplies, and binders.
6. Staff Travel to visit clients and their families at home around Napa, Sonoma, and Solano.
7. Office Rent to provide office for this project. 1,000 square feet expansion necessary to set up office to meet clients.
8. Training costs include cost of training material for clients and their families.
9. Equipment (See attached itemized equipment list)

D. **Administration/Indirect Costs (Maximum of 10%)**

An overview of how these funds are to be used must appear in the budget justification. (A breakdown of administration costs will be provided with each billing statement.)

E. **In-Kind Resources/Costs**

In-Kind resources/costs should be listed here, **do not include on your Budget.**

State Council on Developmental Disabilities

Form 6 Budget
Community Program Development Grant
Cycle 29 - FY 2006-07

Contracting Entity:_____

Name of Proposal:_____

EQUIPMENT LIST

1. Personal Computer and Printer	$3,000
2. Telephone	$ 200
3. Two File Cabinets	$ 500
4. Desk, Chair, Bookcase	$ 700
5. Fax Machine	$ 500

Total Equipment Cost: $ 4,900.00

State Council on Developmental Disabilities

Form 7
Continuation of Funding
Community Program Development Grant
Cycle 29 - FY 2006-07

Contracting Entity:_____

Name of Proposal:_____

This form shall not exceed one (1) page.

1. Identify the source for continuation funding that will be available when the period of the grant funding expires. If your agency is going to be the continuation of funding source, please list. State how the proposal/project will continue.____

2. Describe whether the continuation of funding source is from a government or a private agency. Provide written verification from that agency for the continuation of funds.
   ____

3. If a Regional Center is identified as a continuation of funding source, a vendor code must be provided along with the rate per visit (hourly, daily, monthly, etc.) as set by the Department of Developmental Services' Rates and Vendorization Section.
   ____